

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 16 1948
Registration District No. 42

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22230
Registrar's No. 845

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community 25 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //
(c) City or town St. Joseph //
(If outside city or town limits, write "RURAL")
(d) Street No. 6428 So. 3rd St. 7
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME NEVA L. HOLMES

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Alvin M. 6. (c) Age of husband or wife if dead
7. Birth date of deceased March 23, 1895
(Month) (Day) (Year)

8. AGE: Years 53 Months 4 Days 15 If less than one day
hr. min.

9. Birthplace Leade South Dakota /
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business Home

MOTHER FATHER { 12. Name Unknown //
13. Birthplace Unknown //
14. Maiden name Unknown //
15. Birthplace Unknown //
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Glenn Miller (son)
(b) Address St. Joseph, Missouri

17. (a) Burial (b) Date thereof 8/11/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK CEM

18. (a) Signature of funeral director John C. Jenkins
(b) Address 6054 Prior Ave., City

19. (a) 8-10-48 (b) E. C. Jenkins
(Date received local registrar) (Registrar's signature) ed

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August 8, 1948 day 10: 00 A. M.
year hour minute

21. I hereby certify that I attended the deceased from 7/27/48 to Aug 8, 1948
that I last saw her alive on Aug 8, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Valvular Heart Disease
Acute Congest. Heart Failure

Due to embolism

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury cy

23. Signature [Signature] (M. D. or other) _____
Address 734 [Address] Date signed 8/19/48

SEP 13 1948

AUG 17 1948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Grandal R. Stabe, Registered Apprentice No. *213*

working under my personal supervision.

Signed.....

John E. Rupp

Licensed Embalmer No. *3986*

P. O. Address *St Joseph, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.